TOWN OF ABINGTON, MASSACHUSETTS

BOARD OF HEALTH

PRACTITIONER HEPATITIS B AND TETANUS VACCINE DECLINATION FORM

Instructions: This form is to be signed by the practitioner and the employer, and a copy must be returned to the Abington Board of Health. The employee and employer must both retain a copy of this document for their records. Either sections or both may be completed and signed; however, if a practitioner only declines one of the required vaccines, such as in the event that he or she has previously received the vaccination, the appropriate records will be required to submit as proof. Please read the below statements carefully.

Tetanus Declination Statement

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring the tetanus infection. **I decline the tetanus vaccination at this time.** I understand that by declining this vaccine, I continue to be at risk of acquiring tetanus, a serious disease. I also agree to submit laboratory evidence signed by a physician indicating that I do not have, and have not been exposed to tetanus **every six months**. I agree that should I fail to submit the proper lab results every six months my license will be revoked.

_____ _____

Practitioner's Name (Printed) Practitioner's Signature

_____ _____

Company Employer's Signature

_____

Date

Hepatitis B (HBV) Virus Declination Statement

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring the hepatitis B virus (HBV) infection. **I decline the hepatitis B vaccination at this time.** I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. I also agree to submit laboratory evidence signed by a physician indicating that I do not have, and have not been exposed to hepatitis B **every six months**. I agree that should I fail to submit the proper lab results every six months my license will be revoked.

_____ _____

Practitioner's Name (Printed) Practitioner's Signature

_____ _____

Company Employer's Signature

_____

Date